



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG TERM CARE REGULATION
CERTIFICATION OF ELECTRIC WIRING

FACILITY ID NUMBER

FACILITY NAME		FACILITY TYPE <input type="checkbox"/> RCF I <input type="checkbox"/> RCF* (II) <input type="checkbox"/> ALF <input type="checkbox"/> ALF** <input type="checkbox"/> ICF <input type="checkbox"/> SNF	
ADDRESS (STREET, CITY, ZIP CODE)			
OWNER		ADMINISTRATOR	

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, HAVE MADE AN INSPECTION OF THE ELECTRIC WIRING IN THE ABOVE-NAMED ESTABLISHMENT, AND FIND THAT THE ELECTRICAL INSTALLATION IS IS NOT ESSENTIALLY IN COMPLIANCE WITH THE REQUIREMENTS OF THE NATIONAL ELECTRICAL CODE INsofar AS THE INSTALLATION IS CONCERNED, AND IS IN SAFE OPERATING CONDITION.

REMARKS

SIGNATURE		PRINT NAME		TITLE	
NAME OF COMPANY			TELEPHONE NUMBER		DATE

ADDRESS (STREET, CITY, ZIP CODE)

RETURN TO:	MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES DIVISION OF REGULATION AND LICENSURE SECTION FOR LONG TERM CARE REGULATION REGION
	ADDRESS
	CITY, STATE, ZIP CODE